|  |  |
| --- | --- |
| NAME |  |
| EMAIL ADDRESS |  |
| UNIVERSITY I.D.# |  |
| DATE OF BIRTH |  |
| HOME ADDRESS |  |
| CITY, STATE, AND ZIP CODE |  |
| TELEPHONE # |  |
| STATE HANDICAPPED PERMIT # (if any) |  |
| STATE PERMIT EXPIRATION DATE |  |

Please provide your attending physician’s name, address, telephone and fax numbers below so we may send him/her a letter requesting a recommendation for handicapped parking at the University of Louisville. This information will be held in strict confidence. Information received will be used solely for the purpose of determining eligibility for handicapped parking at the University of Louisville. All long term handicapped permit approvals will be reviewed after four years.

|  |  |
| --- | --- |
| PHYSICIAN’S FULL NAME |  |
| ADDRESS |  |
| CITY, STATE, AND ZIP |  |
| TELEPHONE # |  |
| FAX # |  |

MEDICAL AUTHORIZATION RELEASE: This signature authorizes the above listed physician to provide the necessary information to the University of Louisville Parking Office for the purpose of issuing handicapped parking privileges on campus.

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If additional accommodations (other than parking) are needed, students please contact the Disability Resource Center at 852-6938, and employees, please contact Human Resources at 852-6258.